SERVICE ACCESS AND AUTHORIZATION

After the assessment and any other documentation are reviewed to determine if the beneficiary meets nursing facility level of care and other program requirements, the plan of care (POC) is developed based on the results. The POC includes the:

1. Type of supports needed; and

2. Amount of services needed.

Provider Selection

At the in-home assessment visit, the long term care (LTC) access contractor provides a current list of enrolled Medicaid long term – personal care services (LT-PCS) providers in the region. The beneficiary is instructed to contact providers in order to make their selection. This enables the beneficiary to have freedom of choice (FOC) for the provider who will administer services, if they are eligible for LT-PCS. It is the beneficiary's responsibility to inform the LTC Access contractor of their decision.

The contractor will send the selected provider the "Agreement to Provide Services" form. Providers will need to meet with the beneficiary to review the POC and discuss provision of the services.

If the provider agrees to provide the services, the "*Agreement to Provide Service*s" form must be signed and returned to the LTC assess contractor within 14 calendar days. If approved for services, an approval notice is mailed to the beneficiary along with a copy of the POC and the approved interRAI assessment. (Refer to Appendix B for contractor information).

If the chosen provider declines to serve an individual, the provider must provide to the Office of Aging and Adult Services (OAAS) or its designee, written documentation that supports an inability to meet the individual's needs, or documentation that all previous efforts to provide services and supports have failed and there is no option but to refuse services. The individual will then be asked to choose another provider.

Prior Authorization

All services under LT-PCS must be prior authorized. Prior authorization (PA) is the process to approve specific services for a Medicaid beneficiary by an enrolled Medicaid provider prior to service delivery and reimbursement. The purpose of PA is to validate the service requested as medically necessary and to ensure that it meets criteria for reimbursement. PA does not guarantee payment for the service as payment is contingent upon the passing of all edits contained within the

claims payment process, the beneficiary's continued Medicaid eligibility, the provider's continued Medicaid eligibility, and the ongoing medical necessity for the service.

PA is performed by the Medicaid data contractor and is specific to a beneficiary, provider, service code, established quantity of units, and for specific dates of service.

PA revolves around the POC document, which means that only the amount of services specified in the approved POC will be prior authorized. A PA number is assigned, and approved units of service are released on a weekly basis to the provider. The approved units of service must be used for the specified week. Units of service approved for one week cannot be combined with units of service for another week. For PA purposes, a week is defined as beginning midnight Sunday and ending at 11:59 pm the following Saturday.

A PA number will be issued to providers for the service authorization period, unless the beneficiary changes providers.

Services provided without a current PA are not eligible for reimbursement. There will be no exceptions made for reimbursement of services performed without a current PA.

The provider is responsible for the following activities:

1. Checking PAs by accessing Medicaid Eligibility Verification System (MEVS)/ Recipient Eligibility Verification System (REVS) at the beginning of each month to verify that all PAs for services match the approved services in the beneficiary's POC. Any mistakes must be immediately corrected;
2. Verifying that services were documented as specified in Section 30.8 – Record Keeping, and are within the approved service limits as identified in the beneficiary's POC prior to billing for the service;
3. Verifying that services were delivered according to the beneficiary's approved POC prior to billing for the service;
4. Proper use of the Electronic Visit Verification (EVV) system;
5. Inputting the correct date(s) of service, authorization numbers, provider number, and beneficiary number in the billing system;
6. Billing only for the services that were delivered to the beneficiary and approved in the beneficiary's POC;
7. Reconciling all remittance advices issued by the Louisiana Department of Health (LDH) fiscal intermediary with each payment; and

8. Checking billing records to ensure that the appropriate payment was received.

   NOTE: Providers have one-year timely filing billing requirement under Medicaid regulations. See Section 1.4, Timely Filing Guidelines in Chapter General Information and Administration of the *Medicaid Services Manual* at: http://www.lamedicaid.com/provweb1/Providermanuals/manuals/GIA/GIA.pdf

All requests for changes in services and/or service hours must be made by the beneficiary or their responsible representative. A status change assessment will be performed for all requests where a change in the beneficiary's level of functioning is reported and verified.

Re-assessments will be conducted at least once every 18 months to determine ongoing qualification for services.

Post Authorization

LT-PCS requires post authorization before the provider is able to bill for services rendered. Post authorization is verified through EVV.

The data contractor checks the information reported against the prior authorized units of service. Once post authorization is granted, the provider may bill the LDH fiscal intermediary for the appropriate units of service.

Changing Providers

All requests for changes in providers require a new FOC by the beneficiary or their responsible representative. (Refer to 30.4-Beneficiary Rights and Responsibilities, Freedom of Choice of Providers, for details on "good cause" criteria and timelines).

OAAS, or its designee, will provide the beneficiary with the current FOC provider list for their region. Once a new provider has been selected, OAAS or its designee will ensure the new provider is notified of the request. Both the transferring provider and the receiving provider share responsibility for ensuring the exchange of medical and program information which includes:

1. Progress notes from the last six months, or if the beneficiary has received services from the provider for less than six months, all progress notes from date of admission;

2. Current Individualized Service Plan (ISP), current assessments upon which the ISP is based (if applicable);

3. Documentation of the amount of authorized services remaining in the POC

including direct service case record documentation; and

4. Documentation of exit interview.

OAAS or its designee will facilitate the transfer of the above referenced information to the receiving provider and forward copies of the following to the new provider:

1. Most current POC;

2. Current assessments on which the POC is based;

3. Number of services used in the calendar year; and

4. All documents necessary for the new provider to begin providing services.

NOTE: The new provider must bear the cost of copying, which cannot exceed the community's competitive copying rate.

Prior Authorization for New Providers

OAAS or its designee will complete a POC revision that includes the start date for the new provider and the end date for the transferring provider. A new PA will be issued to the new provider with an effective starting date as indicated on the POC revision. The transferring provider's PA number will expire on the end date as indicated on the POC revision.